Commonwealth of Kentucky
Department of Employee Insurance
2010 KEHP Checklist for New Employees

Name	Social Security Number
Agency Name	Agency #

Following is a list of your rights and responsibilities regarding the Kentucky Employees' Health Plan (KEHP). Read this form carefully and make sure you understand each item. You may direct your questions to your Insurance Coordinator at _____ or you may contact the Department of Employee Insurance at 888-581-8834 or 502-564-1205.

As a new employee, I understand that:

_____I have 30 calendar days from my date of employment to make a health insurance election under the Kentucky Employees Health Plan (KEHP), which includes enrolling in a health insurance plan, Flexible Spending Account and/or waiving coverage. The 30 days are counted beginning with the day after my hire date. If I am an employee of an agency that has a different probationary period, I must sign and date my application no later than 30 days prior to my coverage effective date.

_____ I have received and read the "Notice to Employees 65 and Over"

_____ I understand that If I am 65 or over that I have same opportunity to enroll in KEHP as any other active employee.

_____I understand that if I am a return to work retiree over 65 and/or Medicare eligible that I may not be eligible to continue under a Medicare supplement plan offered by a Kentucky retirement system. I must call my retirement system and verify whether I will be eligible for a Medicare supplement or whether I should consider enrolling in a KEHP plan.

_____ I understand that if I am Medicare eligible that my KEHP Health Plan or stand-alone HRA will pay for Medicare-covered expenses, up to the limit of my coverage under the Kentucky program, before applying to Medicare for payment.

_____I must submit all applications for health insurance (including a waiver of coverage) and Health Reimbursement Account/Flexible Spending Accounts to my agency's Insurance Coordinator **OR** I must make my elections under the KEHP via Web Enrollment.

_____ I will be subject to a one time, 12 month waiting period for pre-existing conditions unless I have had prior creditable coverage for at least 12 months and have had less than a 63 consecutive day break in coverage between the termination of that coverage and the effective date of my coverage with the KEHP. Any prior period of coverage

that is less than 12 months will be applied against the pre-existing condition waiting period.

_____ I must indicate my level of coverage on my application

- SINGLE – Employee Only
- PARENT PLUS – Employee and dependent child(ren)
- COUPLE – Employee and spouse
- FAMILY – Employee, spouse, and dependent child(ren)

_____Once I make my insurance elections, I can not change those elections for the Plan Year unless I experience a valid Qualifying Event or during the Open Enrollment Period.

_____If I meet all requirements and elect to start a cross-reference payment option with my spouse, who is an existing employee of the KEHP and one of us terminates employment, the remaining employee will be set up with a Parent Plus plan.

_____If I fail to enroll within the specified deadline, I will be set up as a waiver with no Health Reimbursement Account. I will only be able to enroll in the KEHP a) if a Qualifying Event takes place that would allow me to enroll or b) during the Open Enrollment Period.

_____Every year there is a defined Open Enrollment Period for health insurance that provides me the opportunity to make ANY type of change in my health insurance coverage and Health Reimbursement/Flexible Spending Account Program, if applicable.

NOTE: CHILDREN COVERED BY COURT ORDER OR ADMINISTRATIVE ORDER MAY NOT BE DROPPED FROM MY INSURANCE, EVEN DURING OPEN ENROLLMENT, UNLESS THERE IS A SUBSEQUENT COURT OR ADMINISTRATIVE ORDER.

_____Outside of the annual Open Enrollment Period, I will only be allowed to make changes to my current plan and, in appropriate circumstances, change plans **within 35 calendar days of a Qualifying Event or up to 60 calendar days for newborns and adoptions (see the Health Insurance Handbook for more information on adding newborns/adoptions and when they will be effective)**. A list of Qualifying Events is available from your Insurance Coordinator or the KEHP's web site at www.kehp.ky.gov.

_____I have been directed to the Summary Plan Description on the KEHP's web site (www.kehp.ky.gov) where I can find all relevant information pertaining to my insurance coverage.

_____I have been directed to the Kentucky Employees Health Plan Handbook on the KEHP's web site where I can find all relevant information pertaining to my options for health insurance coverage.

_____It is my responsibility to sign and date the appropriate form requesting corresponding changes to my plan and give to my agency's Insurance Coordinator no later than 35 calendar days of any event that may affect my coverage.

_____The State offers a Premium Conversion program that allows me to pay my portion of the health insurance premium with pre-tax dollars. I understand that I will automatically be enrolled in the program by virtue of enrolling in health insurance, unless I sign a post-tax form **OR** my dependent(s) does not meet the pre-tax qualifications.

_____My coverage will begin no earlier than on the first day of the second month following my employment hire date.

_____If I experience a COBRA Qualifying Event, such as, but not limited to, termination of employment, I have the right to continue my health insurance at my own expense under COBRA.

_____If I decide that I do not want the state-sponsored health insurance at this time, I can waive (decline) coverage by completing the appropriate paperwork. If I waive coverage because I am covered under my spouse's plan, I will be allowed to enroll in a plan through the KEHP if one of the following occurs:

1. my spouse's employer group health insurance terminates;
2. loss of eligibility;
3. if COBRA coverage is involved, the COBRA coverage expires;
4. my spouse's employer ceases contributing to the plan; or
5. loss of a group health insurance policy.

Check with your spouse's health plan before waiving coverage. Some companies will not cover you if you are eligible for health benefits through your own employer.

_____I may have the opportunity to enroll in the Flexible Spending Account (FSA) program, if applicable, no later than 30 calendar days from my date of employment. I have obtained the appropriate FSA information and application and have been given a chance to ask questions pertaining to the coverage by my Insurance Coordinator.

_____I may contribute my own money into either the Healthcare FSA or Dependent Care FSA. Once I have directed money into the Healthcare FSA, changes are permitted for a HIPAA Special Enrollment Right or a Change in Status (Qualifying Event) if the change is requested no later than 35 calendar days of the date of the event. Changes are allowed to the Dependent Care FSA with an approved Change in Status. Refer to the Qualifying Event Chart.

NOTE: NO QUALIFYING EVENT ALLOWS MEMBERS TO STOP HEALTH INSURANCE IN ORDER TO ENROLL IN A HEALTH REIMBURSEMENT ACCOUNT.

Have you worked for any other agency participating in the Kentucky Employees Health Plan within the last 11 days?
Yes ___ No ___
If yes, please give name of agency and date terminated or transferred.

_____ _____/_____/_____
Agency **Last day worked**

Are you retired from a state-sponsored retirement system?

Yes ___ No ___
If yes, please specify which system:
_____Judicial Retirement Plan
_____Legislators Retirement Plan
_____KCTCS
_____Kentucky Retirement Systems
_____Kentucky Teachers' Retirement System

I acknowledge that I have received copies of the following:
_____Flexible Spending Account Information, if applicable
_____Memorandum regarding Notice of Special Enrollment Rights and Women's Health and Cancer Right Act
_____Other _____

I certify that I have had my health insurance and Flexible Spending Account benefits explained and that I understand the benefits and my responsibilities.

_____ _____
Employee Signature **Date**

_____ _____